GRIFFIN HEALTH SERVICES CORPORATION

The Griffin Hospital, Griffin Faculty Physicians & GHSC's subsidiaries or affiliates

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Information

Patient Name: _____Date of Birth: ____/_____/_____

Address: _____City: _____ State: _____ Zip: _____

Phone Number (___)_____If Patient is a minor, do they reside with their parent/s? ___ Yes ___

If requesting records from **Griffin Hospital**, please check here ☐

Requests should be directed to:

Mail: Griffin Hospital
Medical Records Department
130 Division Street, Derby, CT 06418

Fax: 203-732-1390 **Phone: 203-732-7390**

You are also able to request and download your medical records utilizing the Griffin Hospital Patient Portal. Please contact our medical records department for assistance.

If requesting records from **Griffin Faculty Physicians**, please check here ☐

Requests should be directed to:

Mail: Griffin Faculty Physicians, Record Request
67 Maple Ave
Derby, CT 06418

Fax: 1-844-329-4009 **Phone: 203-732-1330**

You are also able to request and download your medical records utilizing the Griffin Faculty Physician's Patient Portal. Please contact GFP Offices for assistance.

I hereby authorize Griffin Health Services Corporation (including but not limited to Griffin Hospital and Griffin Faculty Physicians) to ***(check applicable)*** ☐ disclose/release records to ☐ obtain from facility listed below the medical records described in this release form.

Name: _____ Phone Number: _____

Address: _____

City: _____ State:_____ Zip: _____

Email: _____ Fax Number: (Care Facilities Only) _____

Purpose: The purpose of this request is (please check one)

___Continuing care ___ Legal ___ Disability ___ Insurance ___ Worker's Compensation ___ Personal ____ other

If other, please specify:

Information requested to release: Date(s) of Service: From: _____ To _____

___Abstract of Record (summary) ___ Complete Record ___ Emergency Room Record ___Office Visit Notes

___History & Physical Report ___ Discharge Summary ___ Radiology Reports ___ Radiology CD

___Operative / Procedure Report ___ PT/OT/ST Record ___ Cardiology Testing ___ Sleep Lab

___Laboratory Reports ___ Pathology Reports ___ Pulmonary Testing ___ Billing Statement

___ Medication / Vaccine Record ___Other (must specify) _____

Psychotherapy ____ Psychotherapy notes only (if *this form is being used to authorize the release of psychotherapy notes, this same form must be filled out again, separately, to authorize the release of any other health information)*

If records contain any of the following sensitive information, please place your initials where applicable to indicate in this section that you specifically authorize the release of these sensitive records:

Drug/Alcohol Abuse: _____ (must be initialed) **HIV/AIDS/STD:** _____ (must be initialed)

Mental Health: _____ (must be initialed) **Genetic Testing**: _____ (must be initialed)

Reproductive Health Care Services: _____ (must be initialed)

Patient Name: **DOB:**_

Format Requested (check one): ___ Hardcopy ___ Electronic ___ CD ___ Other: _____

Delivery Method: ____ Pick Up ___ Receipt of Encrypted Email* ___ US Mail ___ Fax (only if a provider)

*If email option is selected, the patient records will be sent via encrypted email unless the patient provides written request to send them without encryption.

In accordance with state and federal laws, I understand that, if the recipient of the information is not a health care provider or health plan covered by the federal Privacy Rule, the information used or disclosed as described above may be redisclosed by the recipient and is no longer protected by the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as genetic testing information, substance abuse treatment information, HIV/AIDS-related information, psychiatric/mental health information and reproductive health care information. I have been informed that my refusal to grant consent to release of information relating to psychiatric treatment will not jeopardize my right to obtain present or future psychiatric treatment except where disclosure of the communication and records is necessary for treatment. I understand that I am not required to sign this authorization as a condition of treatment, payment, enrollment or eligibility for benefits. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already taken in reliance on the authorization. The revocation letter should be sent to the locations listed on page 1.

This authorization will expire on _____/_____/_____. If no expiration date is specified, authorization will expire 12 (twelve) months from date of signature. By signing below, I acknowledge that I have read and understand this authorization form.

_____ _____

Signature of Patient or Authorized Representative (Guardian/Agent/Surrogate) Date

_____ _____

Printed Name of Authorized Representative Relationship to Patient/ Authority to Act on Their Behalf

If signed by the Patient's Representative, specify the relationship to the patient and authority to act on their behalf. If the patient is a minor (under 18) or has a legal guardian, in most cases, the patient's parent or legal guardian must sign this authorization. A copy of the legal documentation must be provided. If a minor patient is receiving treatment for psychiatric conditions, drug/alcohol abuse, sexually transmitted disease (STD) or HIV/AIDS, genetic testing, and reproductive health care services the minor's consent may be required for disclosure of records. If the hospital/provider determines that the minor's consent is necessary to release the requested records, the hospital/provider will contact the minor to obtain their authorization.

NOTICE & PROHIBITIONS ON REDISCLOSURE

Minors: If a minor has the authority to consent to a particular health care service without parental or other consent, or if the parent or guardian has agreed to confidentiality between the provider and the minor, the minor has sole authority to exercise his or her rights under HIPAA. For example, under appropriate circumstances, minors may consent to their own HIV testing and treatment, treatment for alcohol and drug abuse, outpatient mental health treatment, or treatment of sexually transmitted diseases without parental consent. In cases where the minor provides his or her consent, parents and others will not be recognized as personal representatives and so will not have access to the minor patient's protected health information (PHI) related to the treatment.

Psychiatric Records and Communications: If the information released constitutes confidential psychiatric information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it or of using it for any purpose other than indicated above without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

Drug and Alcohol Abuse Records: If the information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

HIV/AIDS-Related Information: If the information released constitutes confidential HIV-related information protected under Connecticut law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Reproductive Health Care Services (Connecticut): Information regarding the provision and receipt of reproductive health care services is protected under Connecticut law (Public Act No. 22-19). "Reproductive health care services" include all medical, surgical, counseling, or referral services relating to the human reproductive system, including, but not limited to, services relating to pregnancy, contraception, or the termination of a pregnancy. State law prohibits the disclosure of any communication about reproductive health services from a patient or the patient's relating conservator, guardian, or other authorized legal representatives, or any information obtained by a personal examination of the patient relating to reproductive health services, without the written consent of the person to whom it pertains, except in limited circumstances as outlined in the law. As the patient, or the patient's conservator, guardian, or other authorized legal representatives, you have the right to withhold such written consent.